Exhibit 10

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
OAKLAND DIVISION

IN RE: SOCIAL MEDIA ADOLESCENT ADDICTION/PERSONAL INJURY PRODUCTS LIABILITY LITIGATION,

This Document Relates to:

[redacted] v. META PLATFORMS, INC. AND INSTAGRAM, LLC; BYTEDANCE INC.; BYTEDANCE LTD.; TIKTOK, LTD.; TIKTOK

Case Caption and Civil Action No.:

[redacted]

MDL No. 3047

Case No. 4:22-MD-03047-YGR

PLAINTIFF FACT SHEET

Full Name of Plaintiff:

First Name:

[redacted]

Middle Name:

Last Name:

[redacted]

PLAINTIFF FACT SHEET

Please provide the following information for each plaintiff who claims that use of Defendants' platforms (Facebook, Instagram, Snapchat, TikTok, and YouTube) caused them (or a person who died) injury as alleged in the above-captioned litigation.

In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, provide as much information as you can, including by review of documents or materials in your or your attorneys' custody or possession. Be as specific as possible in all of your answers. If you cannot recall a specific date requested, provide the approximate date to the best of your recollection. For example, if you recall the year and month of an event, but not the day, complete the year and month, but enter "00" for the day.

This Plaintiff Fact Sheet is an electronic version that expands to accommodate as much information as is necessary to fully answer any of these questions, including by adding rows or columns to tables. You must fill out the applicable appendix for each entity you have named as a Defendant. Please do not leave any questions unanswered or blank.

You may and should consult with your attorney if you have any questions regarding the completion of this form.

This Plaintiff Fact Sheet constitutes discovery responses subject to Federal Rules of Civil Procedure. This Plaintiff Fact Sheet and the information provided herein will be used only for this litigation and is designated Confidential under the Protective Order. Plaintiffs do not concede the relevance or admissibility of any of the information herein.

I. CASE INFORMATION

A. Name of the court in which the complaint was initially filed:

United States District Court; Northern District of California

B. Case number in court in which complaint was originally filed:

[redacted]

C. Are you alleging in this case that you began using Facebook, Instagram, Snapchat, TikTok, or YouTube when you were under thirteen years old?

Choose your answer: Yes

****IMPORTANT****

DEFINITION OF "RELEVANT TIME PERIOD"

If your answer to question I.C. is "YES," then the phrase "Relevant Time Period" throughout this Plaintiff Fact Sheet means from the time you turned **SEVEN (7) years old to today.**

If your answer to question I.C. is "NO," then the phrase "Relevant Time Period" throughout this Plaintiff Fact Sheet means from the time you turned **TEN (10) years old to today.**

II. REPRESENTATIVE CAPACITY

Only complete this section if you have filed this lawsuit on behalf of a minor, someone who died, or a person who lacks capacity to complete it on their own. When you complete this section of this form (Section II, "Representative Capacity"), "you" refers to the person filling out this form. When you complete the rest of this form "you" refers to the person you are representing.

A. Name of individual completing this Fact Sheet:

First Middle Last

B. Your current address:

Street:

City: State: Zip:

C. What is your relationship to the person upon whose behalf you are completing this Fact Sheet (e.g., parent, guardian, Estate Administrator)?

D. Did the person on whose behalf you are completing this Fact Sheet participate in completing this Fact Sheet?

Choose your answer: _____

1. **If no,** did the person on whose behalf you are completing this Fact Sheet decline to participate?

   Choose your answer: _____

E. If you represent the estate of someone who died or serve as a successor-in-interest, do you contend that use of Defendants' platforms caused or contributed to that person's death?

Choose your answer: _____

F. Have you ever used any Defendant's reporting features to report a negative experience on that platform by the person on whose behalf you are completing this Fact Sheet?

Choose your answer: _____

1. **If yes,** please provide the following information:

Platform Involved (select one)	How Many Times Did You Report	Approximate Dates of Report
		to
		to
		to
		to
		to

III. PERSONAL INFORMATION

If you are completing this Fact Sheet for someone else, assume that "you" means the person who used and was allegedly harmed by Defendants' platforms.

A. Legal name: [redacted] _____ [redacted]
First Middle Last

B. Other names by which you have been known (including maiden names, if any):

First Name	Middle Name	Last Name

First Name	Middle Name	Last Name

C. Gender: Female

D. Social Security Number: [redacted]

E. Date of birth: [redacted]

F. List all addresses where you lived for the last six (6) years. Include addresses where you lived while at school, if you lived away from home for school (e.g., boarding school or college). For each address, provide the approximate dates you resided at each location:

Address	Date Range of Residence
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present

Address	Date Range of Residence
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present
Street: City: State: Zip:	to ☐ Present

G. **Household Information.** Provide the name of all adults who resided in the same household as you for all the addresses you listed above in III.F.

Name	Relationship to You	Date Range the Individual Resided with You
First: Middle: Last:		to ☐ Present
First: Middle: Last:		to ☐ Present
First: Middle: Last:		to ☐ Present
First: Middle: Last:		to ☐ Present
First: Middle: Last:		to ☐ Present
First: Middle: Last:		to ☐ Present
First: Middle: Last:		to ☐ Present
First: Middle: Last:		to ☐ Present

Name			Relationship	Date Range the Individual Resided with You
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present
First:	Middle:	Last:		to ☐ Present

H. **Educational History.**

Provide the following information about your education for the Relevant Time Period:

1. **Primary and Secondary Schools Attended**

Name of School or Educational Institution	City and State	Dates of Attendance	Grade(s) Completed
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	
	City: State:	to ☐ Present	

2. **Post-Secondary Schools (e.g., Colleges, Trade Schools, Graduate Schools), or Other Educational Institutions, Attended.**

Name of School or Educational Institution	City and State	Dates of Attendance	Degree Awarded	Major or Primary Field
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		

3. During the Relevant Time Period, have you ever been subject to disciplinary action (i.e., detention, in-school suspension, out-of-school suspension, expulsion) by any school or other educational institution?

Choose your answer: _____

(a) **If yes,** provide the following information for each incident of disciplinary action to the best of your recollection:

Name of School or Educational Institution	Date of Disciplinary Action	Type of Disciplinary Action (select all that apply)	Grounds for Disciplinary Action
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	

Name of School or Educational Institution	Date of Disciplinary Action	Type of Disciplinary Action (select all that apply)	Grounds for Disciplinary Action
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	
		☐ Detention ☐ In-School Suspension ☐ Out-of-School Suspension ☐ Expulsion	

I. **Previous Interactions with Law Enforcement and the Legal System.**

1. Have you ever been convicted, as an adult, of a felony or a crime involving fraud or dishonesty?

Choose your answer: _____

(a) **If yes**, please answer all of the following questions that apply to you for each instance:

Charge(s)	
Court Where Action Was/Is Pending	
Date of Conviction	
Sentence Imposed	

Charge(s)	
Court Where Action Was/Is Pending	
Date of Conviction	
Sentence Imposed	

Charge(s)	
Court Where Action Was/Is Pending	
Date of Conviction	
Sentence Imposed	

2. Have you ever been subject to a juvenile delinquency proceeding?

Choose your answer: _____

3. To the best of your knowledge, has any individual who regularly cared for you ever been convicted of a crime related to your care?

Choose your answer: _____

IV. ABUSE / VIOLENCE / DISCRIMINATION

A. Have you ever been the victim of discrimination or harassment on the basis of race/ethnicity, national origin, sex, sexual orientation, gender identity, transgender status, or disability?

Choose your answer: _____

1. **If yes,** please select one of the following options to indicate when the discrimination or harassment occurred:

_____

B. Have you ever been the victim of bullying, cyberbullying, verbal abuse, or emotional neglect?

Choose your answer: _____

1. **If yes,** please select one of the following options to indicate when the bullying, cyberbullying, verbal abuse, or emotional neglect occurred:

_____

C. Have you ever been the victim of physical abuse, physical assault, or physical neglect?

Choose your answer: _____

1. **If yes,** please select one of the following options to indicate when the physical abuse, physical assault, or physical neglect occurred:

_____

D. Have you ever been the victim of rape, sexual abuse, or sexual assault?

Choose your answer: _____

1. **If yes,** please select one of the following options to indicate when the rape, sexual abuse, or sexual assault occurred:

_____

E. Have you ever experienced violence or threats of violence (e.g., a shooting, a threatened shooting, or a bombing) in a school, place of worship, your home, or other place?

Choose your answer: _____

1. **If yes,** please select one of the following options to indicate when the violence or threats of violence occurred:

_____

F. Have you ever been the victim of a crime against your person not listed above?

Choose your answer: _____

1. **If yes,** please select one of the following options to indicate when the crime against your person occurred:

_____

V. EMPLOYMENT AND MILITARY HISTORY

A. Complete the chart below detailing your current employment and all prior employment from when you were fourteen years old through today. Please include any part-time jobs.

Employer	City and State	Date Range of Employment (Month/Year to Month/Year)	Occupation/ Position/Title	Was Your Reason for Leaving related to Medical, Physical, Psychiatric, Psychological, or Emotional Reasons?
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		

Employer	City and State	Date Range of Employment (Month/Year to Month/Year)	Occupation/ Position/Title	Was Your Reason for Leaving related to Medical, Physical, Psychiatric, Psychological, or Emotional Reasons?
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		
	City: State:	to ☐ Present		

B. Have you ever served in any branch of the military?

Choose your answer: _____

1. **If yes**, provide the following information:

(a) Branch of service:

_____

(b) Rank upon discharge:

_____

(c) Type of discharge:

_____

VI. MEDICAL BACKGROUND

You must complete and execute the attached authorization to release your medical records and answer the following questions.

A. For the Relevant Time Period, identify each healthcare provider that you saw on an outpatient basis for any physical, mental, or neurodevelopmental condition that lasted more than three months. Include all doctors, psychiatrists, dieticians, nutritionists, neuropsychologists, psychologists, therapists, licensed clinical social workers, nurse practitioners, and physician assistants. *If you saw multiple health care providers within the same medical practice, you are not required to list each doctor, nurse practitioner, or physician assistant you may have seen as part of that group; rather, include the name of the health care provider you primarily saw at the medical practice, and identify the medical specialties of all healthcare providers you saw.*

Name of Medical Practice or Provider	Specialty	Provider's Address, Phone Number, and Email	Date Range as Patient	Condition/Reason for Consultation
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	

Name of Medical Practice or Provider	Specialty	Provider's Address, Phone Number, and Email	Date Range as Patient	Condition/Reason for Consultation
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	

Name of Medical Practice or Provider	Specialty	Provider's Address, Phone Number, and Email	Date Range as Patient	Condition/Reason for Consultation
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	

Name of Medical Practice or Provider	Specialty	Provider's Address, Phone Number, and Email	Date Range as Patient	Condition/Reason for Consultation
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	

Name of Medical Practice or Provider	Specialty	Provider's Address, Phone Number, and Email	Date Range as Patient	Condition/Reason for Consultation
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	
		Street: City: State: Zip: Phone: Email:	to ☐ Present	

B. Identify every **hospital, clinic, or facility** where you were admitted as an in-patient or presented for an emergency room visit for any physical, mental, or neurodevelopmental condition or treatment/surgery during the Relevant Time Period. *You may exclude emergency room visits for common colds, viruses, or high fevers.*

Dates of ER Visit or Hospital Admission and Discharge	Name and Address of Facility	Reason for Admission	Treatment Received
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		

Dates of ER Visit or Hospital Admission and Discharge	Name and Address of Facility	Reason for Admission	Treatment Received
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		

Dates of ER Visit or Hospital Admission and Discharge	Name and Address of Facility	Reason for Admission	Treatment Received
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		
to	Name: Street: City: State: Zip:		

C. List **all** prescription anti-depressants, anti-anxiety medications, anti-psychotic medications, and other medications for the treatment of any mental health problem that you took for three (3) months or more during the Relevant Time Period:

Medication	Date Range of Use	Prescribing Physician or Healthcare Provider (Name, Address and Phone Number	Pharmacy Used (Name, Address, and Phone Number
	to ☐ Present	Name: Street: City: State: Zip: Phone:	Name: Street: City: State: Zip: Phone:
	to ☐ Present	Name: Street: City: State: Zip: Phone:	Name: Street: City: State: Zip: Phone:
	to ☐ Present	Name: Street: City: State: Zip: Phone:	Name: Street: City: State: Zip: Phone:
	to ☐ Present	Name: Street: City: State: Zip: Phone:	Name: Street: City: State: Zip: Phone:

Medication	Date Range of Use	Prescribing Physician or Healthcare Provider (Name, Address and Phone Number	Pharmacy Used (Name, Address, and Phone Number
	to ☐ Present	Name: Street: City: State: Zip: Phone:	Name: Street: City: State: Zip: Phone:
	to ☐ Present	Name: Street: City: State: Zip: Phone:	Name: Street: City: State: Zip: Phone:
	to ☐ Present	Name: Street: City: State: Zip: Phone:	Name: Street: City: State: Zip: Phone:
	to ☐ Present	Name: Street: City: State: Zip: Phone:	Name: Street: City: State: Zip: Phone:

D. Except for those pharmacies identified in your response to question VI.C, identify every pharmacy that has dispensed medication to you during the Relevant Time Period:

Name of Pharmacy	Address and Phone Number	Name of Medication(s) Dispensed	Date Range You Used Pharmacy
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present

Name of Pharmacy	Address and Phone Number	Name of Medication(s) Dispensed	Date Range You Used Pharmacy
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present

Name of Pharmacy	Address and Phone Number	Name of Medication(s) Dispensed	Date Range You Used Pharmacy
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present
	Street: City: State: Zip: Phone:		to ☐ Present

E. Please identify whether you have ever experienced the following conditions and provide the requested information.

Injury, Illness, or Condition (check all that apply)	Date Injury, Illness or Condition Began	If Not Ongoing, Date Injury, Illness, or Condition Ended
☐ Anxiety		
☐ Depression		
☐ Body dysmorphia[1]		
☐ Anorexia		
☐ Bulimia		
☐ Binge Eating Disorder		
☐ Other eating disorder (specify): _____		
☐ Sleep disorder(s)		
☐ Self-harm		
☐ Suicidal thoughts		
☐ Suicide attempt(s)		
☐ Death by suicide		
☐ Other Injury You Attribute to Conduct of a Defendant (specify): _____		
☐ Other Injury You Attribute to Conduct of a Defendant (specify): _____		

[1] An unreasonable preoccupation with an imagined defect in appearance that causes clinically significant distress or impairment in social, occupational or other areas of functioning.

VII. ALLEGED INJURIES, ILLNESSES, AND CONDITIONS

A. Identify all physical and mental injuries, illnesses, or conditions that you allege were caused or worsened by Defendant's platforms.

Injury, Illness, or Condition (check all that apply)	Date Injury, Illness or Condition Began	If Not Ongoing, Date Injury, Illness, or Condition Ended
☐ Social media addiction		
☐ Anxiety		
☐ Depression		
☐ Body dysmorphia[2]		
☐ Anorexia		
☐ Bulimia		
☐ Binge Eating Disorder		
☐ Other eating disorder (specify): _____		
☐ Sleep disorder(s)		
☐ Self-harm		
☐ Suicidal thoughts		
☐ Suicide Attempt(s)		
☐ Death by suicide		
☐ Other Injury You Attribute to Conduct of a Defendant (specify): _____		
☐ Other Injury You Attribute to Conduct of a Defendant (specify): _____		

[2] An unreasonable preoccupation with an imagined defect in appearance that causes clinically significant distress or impairment in social, occupational or other areas of functioning.

B. Diagnosis of Alleged Injuries, Illnesses, or Conditions

1. Have you been diagnosed by a healthcare professional for any injury, illness, or condition identified in VII.A?

Choose your answer: _____

(a) **If yes,** please provide the following information:

Injury, Illness, or Condition Diagnosed (list all that apply)	**Name of Diagnosing Provider/ Facility/Counselor**	**Address of Provider/Facility/Counselor**
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:

Injury, Illness, or Condition Diagnosed (list all that apply)	Name of Diagnosing Provider/ Facility/Counselor	Address of Provider/Facility/Counselor
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:

Injury, Illness, or Condition Diagnosed (list all that apply)	Name of Diagnosing Provider/ Facility/Counselor	Address of Provider/Facility/Counselor
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:

Injury, Illness, or Condition Diagnosed (list all that apply)	Name of Diagnosing Provider/ Facility/Counselor	Address of Provider/Facility/Counselor
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:
		Street: City: State: Zip:

C. Treatment of Alleged Injuries, Illnesses, or Conditions

1. Have you sought medical treatment for any of the injury, illness, or condition identified in VII.A? Medical treatment includes counseling or therapy sought for psychological, psychiatric, mood, or behavioral disorders or conditions, as well as social, emotional, or other related services at a community health center, school, or other educational institution you attended.

Choose your answer: _____

(a) **If yes,** please provide the following information:

Injury, Illness, or Condition Treated (list all that apply)	Name of Provider/ Facility/Counselor	Address of Provider/Facility/Counselor	Date Range of Treatment	Treatment Received
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	

Injury, Illness, or Condition Treated (list all that apply)	Name of Provider/ Facility/Counselor	Address of Provider/Facility/Counselor	Date Range of Treatment	Treatment Received
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	

Injury, Illness, or Condition Treated (list all that apply)	Name of Provider/ Facility/Counselor	Address of Provider/Facility/Counselor	Date Range of Treatment	Treatment Received
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	

Injury, Illness, or Condition Treated (list all that apply)	Name of Provider/ Facility/Counselor	Address of Provider/Facility/Counselor	Date Range of Treatment	Treatment Received
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	
		Street: City: State: Zip:	to ☐ Present	

2. Have you been hospitalized or received in-patient treatment for any of the injury, illness, or condition identified in VII.A?

Choose your answer: _____

(a) **If yes,** please provide the following information:

Injury, Illness, or Condition Treated (list all that apply)	Type of Facility	Name and Address	Date of Admission	Date of Discharge	Treatment Received
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			

Injury, Illness, or Condition Treated (list all that apply)	Type of Facility	Name and Address	Date of Admission	Date of Discharge	Treatment Received
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			

Injury, Illness, or Condition Treated (list all that apply)	Type of Facility	Name and Address	Date of Admission	Date of Discharge	Treatment Received
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			

Injury, Illness, or Condition Treated (list all that apply)	Type of Facility	Name and Address	Date of Admission	Date of Discharge	Treatment Received
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			
		Name: Street: City: State: Zip:			

3. Has any physician or other healthcare provider told you that any injury, illness, or condition identified in VII.A is related to your use of any of Defendants' platforms? *You do not need to list any retained expert witnesses.*

Choose your answer: _____

(a) **If yes**, provide the physician's or healthcare provider's name and address and the approximate date of that discussion:

Healthcare Provider's Name	Address	Approximate Date of Discussion
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	

Healthcare Provider's Name	Address	Approximate Date of Discussion
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	
	Street: City: State: Zip:	

VIII. INSURANCE

A. Provide the following information for each private or public health insurance program with whom you had health insurance coverage during the Relevant Time Period. Include all private insurance and public assistance, if applicable:

Name and Address of Insurance Company or Public Assistance	Policy Number	Name of Policy Holder	Approx. Dates of Coverage
Name: Street: City: State: Zip:			to ☐ Present
Name: Street: City: State: Zip:			to ☐ Present
Name: Street: City: State: Zip:			to ☐ Present
Name: Street: City: State: Zip:			to ☐ Present

Name and Address of Insurance Company or Public Assistance	Policy Number	Name of Policy Holder	Approx. Dates of Coverage
Name: Street: City: State: Zip:			to ☐ Present
Name: Street: City: State: Zip:			to ☐ Present
Name: Street: City: State: Zip:			to ☐ Present
Name: Street: City: State: Zip:			to ☐ Present
Name: Street: City: State: Zip:			to ☐ Present

IX. ALCOHOL, TOBACCO, AND DRUG USE

A. Alcohol

1. During the Relevant Time Period, have you consumed alcohol regularly (i.e., once or more per week)?

   Choose your answer: _____

2. Have you ever sought treatment or been given a professional recommendation or referral for treatment for alcohol addiction?

   Choose your answer: _____

3. Have you ever received treatment for alcohol addiction?

   Choose your answer: _____

   (a) If yes, when?

   _____ to _____

B. Tobacco

1. During the Relevant Time Period, have you used tobacco (including cigarettes, cigars, pipes, chewing tobacco/snuff, vaping devices, dissolving tobacco, hookah, and/or electronic cigarettes) regularly (i.e., once or more per week)?

   Choose your answer: _____

2. Have you ever sought treatment or been given a professional recommendation or referral for treatment for a tobacco-related addiction?

   Choose your answer: _____

3. Have you ever received treatment for a tobacco-related addiction?

   Choose your answer: _____

   (a) If yes, when?

   _____ to _____

C. Drugs

1. During the Relevant Time Period, have you consumed or ingested (in any manner, including swallowing, smoking, snorting, injecting, or using suppositories) recreational drugs (i.e., legal or illegal drugs used without medical supervision)?

   Choose your answer: _____

2. Have you ever sought treatment or been given a professional recommendation or referral for treatment related to drug use?

   Choose your answer: _____

3. Have you ever received treatment related to drug use?

   Choose your answer: _____

   (a) If yes, when?

   _____ to _____

D. Video Games

1. Have you played video games during the Relevant Time Period?

   Choose your answer: _____

   (a) **If yes**, provide the following information:

   (i) At any point during the Relevant Time Period, did you play video games more than two hours per day or 14 hours per week?

   Choose your answer: _____

   (ii) Have you ever sought treatment or been given a professional recommendation or referral for treatment related to gaming?

   Choose your answer: _____

   (iii) Have you ever received treatment related to gaming?

   Choose your answer: _____

   (A) If yes, when?

   _____ to _____

E. Gambling

1. During the Relevant Time Period, have you engaged in gambling regularly? (i.e., once or more per week)

   Choose your answer: _____

2. Have you ever sought treatment or been given a professional recommendation or referral for treatment related to gambling?

   Choose your answer: _____

3. Have you ever received treatment related to gambling?

   Choose your answer: _____

   (a) If yes, when?

   _____ to _____

F. Have you ever received treatment for any other addiction?

Choose your answer: _____

1. **If yes,** please indicate the addiction(s) for which you received treatment:

_____

X. **DAMAGES**

A. Are you claiming any lost wages or earning capacity?

Choose your answer: _____

1. **If yes**, please provide the following information:

(a) Provide your annual income for each year during the period beginning at age fourteen (14) through today:

Year	Gross Annual Income

(b) From age 14 to today, has any doctor told you that you should not work for some period of time as a result of the injuries you allege in this case?

Choose your answer: _____

(i) **If yes**, state the name(s) and address(es) of such health care provider(s):

Healthcare Provider's Name	Address
First: Middle: Last:	Street: City: State: Zip:
First: Middle: Last:	Street: City: State: Zip:

Healthcare Provider's Name	Address
First: Middle: Last:	Street: City: State: Zip:
First: Middle: Last:	Street: City: State: Zip:
First: Middle: Last:	Street: City: State: Zip:
First: Middle: Last:	Street: City: State: Zip:

(c) From age 14 to today, have you quit or taken a medical leave(s) of absence from any job as a result of the injuries you allege in this case?

Choose your answer: _____

(i) **If yes**, identify each employer from which you quit or took leave and when:

Employer	Dates
	Quit: Leave:
	Quit: Leave:
	Quit: Leave:
	Quit: Leave:

B. Do you claim medical expenses (including for mental health, psychiatric, psychological, or other treatment) as a result of the injuries you allege in this case?

Choose your answer: _____

1. **If yes,** please approximate the total amount of medical expenses you are claiming:

_____

C. Do you claim your education was disrupted (e.g., disciplinary issues, impact on grades, impact on attendance, etc.) as a result of your use of Defendants' platforms?

Choose your answer: _____

1. **If yes,** answer the following:

(a) During the Relevant Time Period, have you ever received remedial or supplemental academic, social, or emotional services at a community center, school, or educational institution you attended?

Choose your answer: _____

(i) **If yes**, provide the following information:

Name of Community Center, School, or Educational Institution	Date Range of Services	Description of Services Provided
	to	
	to	
	to	

D. Is anyone claiming loss of consortium and/or loss of services as a result of your use of Defendants' platforms?

Choose your answer: _____

1. **If yes,** please identify all persons claiming loss of consortium and/or loss of services, to the best of your knowledge, and your relationship to each person (e.g., spouse, child):

Name	Address	Relationship
First: Middle: Last:	Street: City: State: Zip:	
First: Middle: Last:	Street: City: State: Zip:	

Name	Address	Relationship
First: Middle: Last:	Street: City: State: Zip:	
First: Middle: Last:	Street: City: State: Zip:	
First: Middle: Last:	Street: City: State: Zip:	
First: Middle: Last:	Street: City: State: Zip:	

XI. ELECTRONICS USAGE

A. At what age did you first have regular access to a mobile phone, tablet, or computer (i.e. once per week or more)?

_____

XII. SOCIAL MEDIA USE

A. Identify whether you used the following platforms (fill in all that apply), the age at first use, and the approximate dates of use:

Platform	Have You Used This Platform?	Age at First Use	Date Range of Use
Facebook			to ☐ Present
Instagram			to ☐ Present
Snapchat			to ☐ Present
TikTok			to ☐ Present
YouTube			to ☐ Present

B. To the best of your ability, please estimate your ***average*** usage of each Defendant's platform:

Platform	Average Number of Days Accessed Per Week	Average Number of Minutes Per Day on Days You Accessed	Average Number of Times Accessed Per Day on Days You Accessed
Facebook			
Instagram			
Snapchat			
TikTok			
YouTube			

C. To the best of your ability, please estimate your ***average nightly*** usage of each Defendant's platform between the hours of 10:30 P.M. and 6 A.M.:

Platform	Average Number of Nights Accessed Per Week	Average Number of Minutes Per Night on Nights You Accessed	Average Number of Times Accessed Per Night on Nights You Accessed
Facebook			
Instagram			
Snapchat			
TikTok			
YouTube			

D. To the best of your ability, please estimate your ***peak*** usage of each Defendant's platform:

Platform	Age at Peak Usage	Approximate Minutes Per Day at Peak Usage
Facebook		
Instagram		
Snapchat		
TikTok		
YouTube		

E. For each Defendant's platform, have you ever created an account(s) with an incorrect date of birth or age?

1. Facebook: Choose your answer: _____
2. Instagram: Choose your answer: _____
3. Snapchat: Choose your answer: _____
4. TikTok: Choose your answer: _____
5. YouTube: Choose your answer: _____

F. Have you used any other social media platforms? Choose your answer: _____

1. **If yes**, identify the platform, the username(s) you used, the email address(es) you used, the approximate dates of use, your age at first use, and your best estimate of your average frequency of use:

Platform	Username(s)	Email Address(es)	Approximate Dates of Use	Age at Time of First Use	Average Frequency of Use When You Used This Platform
			to ☐ Present		

Platform	Username(s)	Email Address(es)	Approximate Dates of Use	Age at Time of First Use	Average Frequency of Use When You Used This Platform
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		
			to ☐ Present		

Platform	Username(s)	Email Address(es)	Approximate Dates of Use	Age at Time of First Use	Average Frequency of Use When You Used This Platform
			to ☐ Present		
			to ☐ Present		

G. If you have ever tried to delete or deactivate your Facebook, Instagram, Snapchat, TikTok, or YouTube account, provide the following information:

Platform	Delete or Deactivate?	Approximate Date of Attempt	Did You Succeed in Deleting or Deactivating your Account?	If you Successfully Deactivated your Account, Did you Later Reactivate it?

H. If you have ever used any of Defendants' platforms through another person's account, provide the following information regarding those accounts if known:

Platform	Account Username	Email Address Associated with Account (if known)	Accountholder's Name	Accountholder's Relationship to You	Date Range of Your Use of the Account
			First: Middle: Last:		to
			First: Middle: Last:		to
			First: Middle: Last:		to
			First: Middle: Last:		to

Platform	Account Username	Email Address Associated with Account (if known)	Accountholder's Name	Accountholder's Relationship to You	Date Range of Your Use of the Account
			First: Middle: Last:		to

I. Have you ever used any app or electronic mechanism to keep content on a device private, such as Calculator+, Hide it Pro (HIP), Vault, AppLock, Secret Calculator?

Choose your answer: _____

1. **If yes,** identify the following information:

App or Mechanism Used	Approximate Date App was Downloaded	Apps/Content Hidden in App	App Username (If Any)

J. Have you ever been paid by a Defendant in connection with your use of their platform?

Choose your answer: _____

1. If yes, identify the platform(s):

Platform(s) Involved (select all that apply)
☐ Facebook
☐ Instagram
☐ Snapchat
☐ TikTok
☐ YouTube

K. Do you claim injury or damage as a consequence of your participation in a "challenge" on any of Defendants' platforms?

Choose your answer: _____

1. If yes, identify the following information:

Name of Challenge	Approximate Date You First Saw the Challenge Attempted	Platform(s) On Which You Observed and/or Participated in the Challenge	Injury or Damage Caused by the Challenge
		☐ Facebook ☐ TikTok ☐ Instagram ☐ YouTube ☐ Snapchat	
		☐ Facebook ☐ TikTok ☐ Instagram ☐ YouTube ☐ Snapchat	
		☐ Facebook ☐ TikTok ☐ Instagram ☐ YouTube ☐ Snapchat	
		☐ Facebook ☐ TikTok ☐ Instagram ☐ YouTube ☐ Snapchat	
		☐ Facebook ☐ TikTok ☐ Instagram ☐ YouTube ☐ Snapchat	

L. Do you claim that any Defendant facilitated the spread of sexually explicit media depicting or relating to you?

Choose your answer: _____

1. If yes, identify the platform(s) on which this occurred:

Platform(s) Involved (select all that apply)
☐ Facebook
☐ Instagram
☐ Snapchat
☐ TikTok
☐ YouTube

2. Was any other person involved in facilitating the spread of sexually explicit media depicting or relating to you?

Choose your answer: _____

XIII. DEFENDANTS' PLATFORMS

A. **Accessing Defendants' Platforms.**

1. What devices have you used on a routine basis to access Defendants' platforms?

☐ Personal phone	☐ Parent or guardian's phone	☐ School tablet or computer
☐ Personal tablet	☐ Friend or sibling's phone	☐ Other: _____
☐ Personal computer	☐ Family tablet or computer	

2. Have you or anyone else placed or attempted to place restrictions on your access to Defendants' platforms on the devices listed above (e.g., through Screen Time, internet network, physical removal, etc.)?

Choose your answer: _____

B. **Reporting on Defendants' Platforms.** If you have ever used any Defendant's reporting features to report a negative experience on that platform, provide the following information:

Platform Involved (select one)	How Many Times Did You Report	Approximate Dates of Report
☐ Facebook ☐ Instagram ☐ Snapchat ☐ TikTok ☐ YouTube		to
☐ Facebook ☐ Instagram ☐ Snapchat ☐ TikTok ☐ YouTube		to
☐ Facebook ☐ Instagram ☐ Snapchat ☐ TikTok ☐ YouTube		to

Platform Involved (select one)	How Many Times Did You Report	Approximate Dates of Report
☐ Facebook ☐ Instagram ☐ Snapchat ☐ TikTok ☐ YouTube		to
☐ Facebook ☐ Instagram ☐ Snapchat ☐ TikTok ☐ YouTube		to

XIV. FACT WITNESSES

A. Please identify the five individuals (including, but not limited to, family members, friends, educators, and employers) other than your attorney(s) and healthcare providers who you believe possess the most significant information concerning: (1) your use of social media and (2) your claimed injuries, illnesses, and/or conditions:

Name	Address	Relationship to You	Information You Believe They Possess
First: Middle: Last:	Street: City: State: Zip:		
First: Middle: Last:	Street: City: State: Zip:		
First: Middle: Last:	Street: City: State: Zip:		

Name	Address	Relationship to You	Information You Believe They Possess
First: Middle: Last:	Street: City: State: Zip:		
First: Middle: Last:	Street: City: State: Zip:		

XV. AUTHORIZATIONS

For all authorizations listed herein, the starting date for the records release is the beginning of the Relevant Time Period to today.

A. Authorizations for Release of Health Information Pursuant to HIPAA
Please provide a signed (but undated) Limited Authorization to Disclose Health Information Pursuant to HIPAA, attached as **Exhibit "A-1**,**"** and a signed (but undated) Limited Authorization to Disclose Psychological, Psychiatric and Other Mental Health Information, attached as **Exhibit A-2**.

B. If you are claiming lost wages or earning capacity:

1. Please provide a signed (but undated) Authorization to Disclose Employment Records, attached as **Exhibit "B."**

2. Please provide a signed (but undated) Authorization for Release of Workers' Compensation Records, attached as **Exhibit "C."**

3. Please provide a signed (but undated) Authorization for Release of Disability Claims Records, attached as **Exhibit "D."**

C. Authorization for Release of Educational Records

Please provide a signed (but undated) Authorization for Release of Educational Records, attached as **Exhibit "E."**

D. Authorization for Release of Insurance Records

Please provide a signed (but undated) Authorization to Disclose Insurance Information, attached as **Exhibit "F."**

E. Authorization for Release of Medicare and Medicaid Records.

Please provide a signed (but undated) Authorization for Release of Medicaid Information, attached as **Exhibit "G,"** and a signed (but undated) Medicare Authorization to Disclose Personal Health Information Form attached as **Exhibit H.**

XVI. DOCUMENTS IN YOUR POSSESSION, CUSTODY, OR CONTROL

For each of the following questions, indicate whether you have any of the specified materials in your possession, custody, or control, and attach a copy of each document in your possession, custody, or control to this Plaintiff Fact Sheet:

A. All non-privileged documents you reviewed that assisted you in the preparation of your answers to the Short-Form Complaint or this Plaintiff Fact Sheet.

Choose your answer: _____

B. All educational records pertaining to you that are related to disciplinary actions or the symptoms, side effects, or injuries (including mental, psychological, or psychiatric injuries, if any) you are claiming during the Relevant Time Period.

Choose your answer: _____

C. All medical, billing, insurance (including but not limited to your Explanation of Benefits), or other records and/or other documents relating to your use of Defendants' platforms, or the symptoms, side effects, or injuries (including mental, psychological, or psychiatric injuries, if any) you are claiming.

Choose your answer: _____

D. All records of expenditures that you contend are attributable to your alleged injury.

Choose your answer: _____

E. All documents or materials in your possession relating to your physical or mental condition, or the symptoms, side effects, or injuries (including mental, psychological, or psychiatric injuries, if any) you are claiming.

Choose your answer: _____

F. All diary entries; journal entries; notebook entries; posts on social media platforms (including tweets) other than Facebook, Instagram, Snapchat, TikTok, or YouTube; or posts on chat rooms, blogs, message boards, and online support groups made during the Relevant Time Period in which you have discussed the injuries you are claiming.

Choose your answer: _____

G. If you are making a claim for lost wages or lost earning capacity, your W-2s from the time you were fourteen through today, for each year you have filed a tax return.

Choose your answer: _____

H. If you have been the claimant or subject of any Social Security or other disability proceeding related to the injuries you are claiming, all documents in your possession relating to such proceeding.

Choose your answer: _____

I. For deceased plaintiffs, the death certificate of the person who died and any certificate or letters of administration that establish the authority of the Representative bringing this lawsuit on behalf of the person who died.

Choose your answer: _____

XVII. **DECLARATION**

I declare under penalty of perjury that, at the time I completed this Plaintiff Fact Sheet, all of the information provided is true and correct to the best of my knowledge, that I have supplied all the documents requested in this Plaintiff Fact Sheet, to the extent that such documents are in my possession, custody, or control, and that I have supplied the applicable Authorizations attached to this declaration.

Date: _____ Signature: _____

Printed name: _____
(Plaintiff or person authorized to sign)

On behalf of _____
(if applicable): (Minor)